

**DNA LABORATORY TEST REQUEST FORM** (Please send this completed form with the specimen)

PATIENT LAST NAME: \_\_\_\_\_ FIRST NAME : \_\_\_\_\_ DOB: \_\_\_\_\_  
 SEX: M / F REF. LAB #: \_\_\_\_\_ DATE COLLECTED: \_\_\_\_\_ DATE RECEIVED: \_\_\_\_\_  
 ETHNIC BACKGROUND: (Circle all that apply) European Caucasian, Hispanic, Native American, African American, Asian, Other

<b>REFERRING PHYSICIAN/ HEALTH PROFESSIONAL:</b> Name: _____ Address: _____ City, State, Zip: _____ Telephone:(_____) _____ FAX:(_____) _____	<b>REFERRING INSTITUTION / CLINIC / LABORATORY:</b> Name: _____ <b>ADDITIONAL REPORTS TO:</b> Name: _____
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**PHYSICIAN SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (Required for Medicare / Medicaid billing)

<b>BILLING INFORMATION:</b> <input type="checkbox"/> <b>REFERRING INSTITUTION</b>  New clients please call laboratory with financial contact information.	<input type="checkbox"/> <b>INSURANCE</b> Name of policy holder: _____ Policy holder DOB: _____ SS # (Guarantor): _____ Address: _____ Phone #: _____ Relationship to patient: _____ Insurance Co. / Policy #: _____ Insurance Co Contact / Phone #: _____	<input type="checkbox"/> <b>Medicaid #:</b> _____ <b>State</b> (MT, WY, CO, UT): _____ <b>SS#:</b> _____  <input type="checkbox"/> <b>SELF PAY</b>  <input type="checkbox"/> <b>Inpatient</b>
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**TEST REQUESTED:** (Please check one or more; test descriptions with CPT codes and prices faxed on request)

<input type="checkbox"/> Hemochromatosis (HFE) Mutations (C282Y / H63D)	<input type="checkbox"/> Beckwith-Wiedemann (LIT1 / KCNQ10T1 Methylation)
<input type="checkbox"/> Factor V Leiden (FVL) Mutation	<input type="checkbox"/> Angelman Syndrome (AS) Methylation
<input type="checkbox"/> Prothrombin (Factor II) Polymorphism	<input type="checkbox"/> Prader- Willi Syndrome (PWS) Methylation
<input type="checkbox"/> Factor V Leiden / Prothrombin / MTHFR Variant	<input type="checkbox"/> Fragile X Syndrome (FMR-1): DNA only
<input type="checkbox"/> Myotonic Dystrophy (DM) Mutation	<input type="checkbox"/> Fragile X Screen: DNA + chromosome analysis
<input type="checkbox"/> Huntington Disease (HD) Mutation	<input type="checkbox"/> Uniparental Disomy Screen (Chromosome _____)
<input type="checkbox"/> X-Chromosome Inactivation	(chromosomes 2, 6, 7, 8, 9, 11, 13, 14, 15, 16, 20, 21)
<input type="checkbox"/> Zygoty (Twin) Studies	* Note: Parents required for UPD studies
<input type="checkbox"/> Maternal Cell Contamination Analysis	<input type="checkbox"/> Other (Specify: _____)
<input type="checkbox"/> Microarray	

**CLINICAL INFORMATION / INDICATION FOR TEST:**

**Clinical Findings:** \_\_\_\_\_ **ICD-9 Code:** \_\_\_\_\_

**Reason for Testing:**  
 Diagnostic                       Family History                       Carrier Testing                       Prenatal

**History (or pedigree):** previous genetic testing: \_\_\_\_\_ **Pregnancy history (gravida / para / ab):** \_\_\_\_\_  
**Gestational age and method (US, LMP):** \_\_\_\_\_

**ADDITIONAL FAMILY MEMBERS TO BE STUDIED AND RELATIONSHIP** (Provide parents names and dates of birth for UPD studies)  
 1. \_\_\_\_\_ 2. \_\_\_\_\_

**SPECIMEN TYPE:** (Please check) PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT.

<input type="checkbox"/> <b>Cultured amniocytes</b> (Two confluent T25 flasks, please retain a backup)	<input type="checkbox"/> <b>Blood:</b> EDTA (purple top tube) or ACD (yellow) 5 to 10 ml, minimum 1 ml for infants, room temp
<input type="checkbox"/> <b>Cultured chorionic villus (CVS) cells</b> (Two confluent T25 flasks, please retain a backup)	<b>For chromosome analysis, also submit 3 to 5 ml sodium heparin (green top)</b>
<input type="checkbox"/> <b>Direct amniotic fluid or CVS</b> (Please call the laboratory to arrange)	<input type="checkbox"/> <b>Tissue, Fixed or Fresh, source:</b> (block or thick sections, please contact lab)
	<input type="checkbox"/> <b>OTHER:</b>

Please submit 3-5 ml maternal blood collected in an EDTA tube for maternal cell contamination study. We strongly recommend this test when chorionic villus samples results indicate a female fetus (we discard the sample if the results are male). If you do not choose to submit this sample, please check the box below which assures that you have discussed this testing with the patient and she declines this additional testing.

**DECLINE**

Med Rec #	Admit #	Shire #
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